Filing at a Glance

Company:	Life Insurance Company of North America
Product Name:	Group Critical Illness Benefits
State:	Arkansas
TOI:	H07G Group Health - Specified Disease - Limited Benefit
Sub-TOI:	H07G.001 Critical Illness
Filing Type:	Form
Date Submitted:	10/24/2012
SERFF Tr Num:	CCGN-128740336
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	12-8002
Implementation Date Requested:	On Approval
Author(s):	Sharon Battle, Brian Smith, Harriet Webb
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	10/26/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** Life Insurance Company of North America
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Group Critical Illness Benefits
Project Name/Number: Evidence of Insurability Form/12-8002

General Information

Project Name: Evidence of Insurability Form
Project Number: 12-8002
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 10/26/2012
State Status Changed: 10/26/2012
Created By: Harriet Webb
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: N/A
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Harriet Webb

Filing Description:

Enclosed for review and approval is form GCI-009320. This form is an evidence of insurability form for use by individuals who apply for group insurance that is subject to the person providing proof of insurability. This form replaces any previously approved versions of form GCI-009320.

The form has not been filed with our state of domicile since Pennsylvania does not require the filing of forms intended for delivery outside their state, pursuant to PA Notices 96-1 and/or 96-13.

We appreciate you taking the time to review this filing, and trust that you will find everything in order. If you should have any questions or require additional information, please do not hesitate to contact me.

Company and Contact

Filing Contact Information

Harriet Webb,
1601 Chestnut St -Two Liberty
Philadelphia, PA 19192

Harriet.Webb@CIGNA.com
215-761-4104 [Phone]

Filing Company Information

Life Insurance Company of North America
1601 Chestnut Street
TL16D
Philadelphia, PA 19192
(215) 761-8442 ext. [Phone]

CoCode: 65498
Group Code: 901
Group Name:
FEIN Number: 23-1503749

State of Domicile: Pennsylvania
Company Type:
State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking #: *CCGN-128740336* ***State Tracking #:*** ***Company Tracking #:*** *12-8002*

State: *Arkansas* ***Filing Company:*** *Life Insurance Company of North America*
TOI/Sub-TOI: *H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*
Product Name: *Group Critical Illness Benefits*
Project Name/Number: *Evidence of Insurability Form/12-8002*

Company	Amount	Date Processed	Transaction #
Life Insurance Company of North America	$50.00	10/26/2012	64306625

SERFF Tracking #:	*CCGN-128740336*	***State Tracking #:***		***Company Tracking #:***	*12-8002*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of North America*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness Benefits*		
Project Name/Number:	*Evidence of Insurability Form/12-8002*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/26/2012	10/26/2012

SERFF Tracking #:	*CCGN-128740336*	***State Tracking #:***		***Company Tracking #:***	*12-8002*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of North America*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness Benefits*		
Project Name/Number:	*Evidence of Insurability Form/12-8002*		

Disposition

Disposition Date: 10/26/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Description of Variability	Approved-Closed	Yes
Form	Evidence of Insurability	Approved-Closed	Yes

SERFF Tracking #:	*CCGN-128740336*	***State Tracking #:***		***Company Tracking #:***	*12-8002*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of North America*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness Benefits*		
Project Name/Number:	*Evidence of Insurability Form/12-8002*		

Form Schedule

Lead Form Number: GCI-009320

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/26/2012	Evidence of Insurability	GCI-009320	POLA	Initial		50.000	Appl, EOI form GCI-009320.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

CRITICAL ILLNESS INSURANCE
[APPLICATION] [EVIDENCE OF INSURABILITY] [ENROLLMENT] [CHANGE] FORM
Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)

[[*For info and customer service for Critical Illness Insurance, call {1-000-000-0000}.*]
[• *All info must be completed by the applicant.*]
• *The applicant, and spouse* [*/Domestic Partner*] *if coverage is requested, must sign and date this form.*
• *This form cannot be considered unless received within {30} days of the date it is dated.*
[• *The Insurance Company must approve your request for insurance before it becomes effective.*]

Important: *Please enter all dates in mm/dd/yyyy format.*]

REASON FOR REQUEST

[❑ NEW HIRE] [❑ INITIAL ENROLLMENT EVENT] [❑ LATE ENTRANT]
[❑ LIFE STATUS CHANGE] [❑ ONGOING ENROLLMENT EVENT] [❑ REINSTATEMENT]

[Please print (preferably in black ink)]

{EMPLOYEE} INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. (Check one) Name: (First) _____ (Last) _____ (MI) ____
Address_____ Apt. # _____ City _____State____ Zip_____
Day Phone _____ Evening Phone _____ Social Security # _____ Date of Birth _____
[Employer _____] [Policy # _____] [ID #_____] [Class _____]
[Occupation _____] [Location _____] [Date of Hire _____] [Annual Salary _____]

[COMPLETE IF ELECTING SPOUSE [/DOMESTIC PARTNER] COVERAGE

[❑ I am currently married and my date of marriage is _____] [❑ I am currently eligible under the insurance as a Domestic Partner*]

Name: (First) _____ (Last) _____ (MI) ____ Social Security # _____ Date of Birth _____

[* *In order to be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or any required Domestic Partner Affidavit on file with your employer, and accepted by the Insurance Company. If you do not currently have a state-registered Domestic Partnership, or an Domestic Partner Affidavit on file with your employer, an Affidavit should be requested from and will be made available to you through your employer.*]]

CRITICAL ILLNESS INSURANCE [Policy Number _____]

[Have you smoked or used any form of tobacco in the last {12} months?
{Employee} ❑ Y ❑ N Spouse [/Domestic Partner] ❑ Y ❑ N]

[Employer-Paid Basic Coverage

Applicant	[Amount]	Guaranteed Issue Amount*
{Employee}	[_____ times salary, to a maximum of $_____]	_____]

Voluntary {Employee}-Paid Coverage

Applicant	Decline	Amount Requested [*(check only one amount)*] [*(amount must be $\{1,000\} increments)*]	[Guaranteed Issue Amount*
{Employee}	❑	[❑ _____] [❑ _____] [❑ _____]	_____
Spouse [/Domestic Partner]	❑	[❑ _____] [❑ _____] [❑ _____]	_____
Child(ren)	❑	[❑ _____] [❑ _____] [❑ _____]	_____]

[Guaranteed Issue Amount is only available during Initial Enrollment and at such other times as identified and outlined in offering materials. Amounts of insurance may be limited by state law.]*

[❑ Health Screening Benefit]
[❑ _____]

[*Premium Amount* $ _____]

[Applicant's Name John Doe] [[Social Security # 111-11-1111] [ID# 3423]]

[I WISH TO MAKE THE FOLLOWING CHANGES TO MY CRITICIAL ILLNESS COVERAGE

Consult with your employer for the coverage election options currently available. When selecting new coverage amounts, please ensure that your election(s) match the amounts[, salary multiples] or unit increments as currently available under your plan.

CHECK THE APPROPRIATE BOXES:

❑ ***Increase, Decrease or Begin Coverage on the Following Individuals as Indicated Below***

[**(Complete the medical questions below if you are electing, or increasing, coverage for yourself or your spouse [/Domestic Partner)**]

Applicant	Current Voluntary Coverage	New Voluntary Coverage	Total Voluntary Coverage
❑ {Employee}			
❑ Spouse [/Domestic Partner]			
❑ Child(ren)			

❑ ***Life Status Change*** ***(check only one of the following boxes, and provide date of change)***

[❑ Marriage] [❑ Divorce] [❑ Annulment] [❑ Legal Separation] [❑ Birth or Adoption of a Child] [❑ Death of Spouse [/Domestic Partner] or Child] [❑ Leave of Absence] [❑ Change in Spouse's [/Domestic Partner's] Employment] [❑ Return to or from Military Duty] [❑ Change from Full-time to Part-time (or vice-versa)]

Date of Life Status Change _____

❑ ***Cancel Coverage on the Following Individuals*** ***(check all that apply)***

❑ {Employee} ❑ Spouse [/Domestic Partner] ❑ Dependent Child(ren)

Effective Date of Cancellation _____

❑ ***Name Change*** ***(Current name / New Name)***

{Employee} _____ / _____

Spouse [/Domestic Partner] _____ / _____]

ACCEPTANCE / DECLINATION

[I accept the insurance coverage(s) chosen above. I authorize my employer to {deduct the needed amounts from my earnings}. If I have not chosen coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability/good health at my own expense and that coverage is subject to the Insurance Company's approval.]

[I authorize the above changes to my {employee} paid coverage. I understand that certain changes may require medical information which will be requested by the Insurance Company if necessary. I authorize my employer to {make the appropriate payroll deductions} for changes noted above.]

Signature_____ Date _____

****You should read and sign the Agreements section that follows in this form****

[Applicant's Name John Doe] [[Social Security # 111-11-1111] [ID# 3423]]

[IMPORTANT
Please complete the following section if needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Instructions for Evidence of Insurability Section

[Complete the employee info in this section if you (i.e., the {Employee}) are:
- applying for Insurance for yourself that is greater than the guaranteed coverage amount, or
- applying for Insurance for yourself [more than {31} days] after you were eligible for the insurance.]

[Complete the spouse [/Domestic Partner] info in this section if:
- applying for Insurance for your spouse [/Domestic Partner] that is greater than the guaranteed coverage amount, or
- applying for Insurance for your spouse [/Domestic Partner] [more than {31} days] after the spouse [/Domestic Partner] is eligible for the Insurance.]

Please indicate your answers for each question by checking the Yes or No box for the question.

	{Employee}	[Spouse [/Domestic Partner]
1. In the past 5 years has any proposed insured received medical advice or treatment for or had:		
• Cancer, carcinoma in situ, blood disorder?	❑ Y ❑ N	❑ Y ❑ N
• Stroke, transient ischemic attack, chronic obstructive lung or pulmonary disease, any disease or disorder of the heart, polycystic kidney disease, chronic renal failure, any liver disorder, diabetes, macular degeneration, retinitis pigmentosa, acquired immunodeficiency syndrome, HIV or organ transplant?	❑ Y ❑ N	❑ Y ❑ N
2. In the past 6 months has any proposed insured:		
• Been recommended to have a diagnostic test related to cancer that has not been taken or for which results have not been received, or had a diagnostic or screening test related to cancer for which follow-up was recommended other than future routine screening?	❑ Y ❑ N	❑ Y ❑ N
• Been treated with three or more medications for high blood pressure?	❑ Y ❑ N	❑ Y ❑ N
3. Indicate Height and Weight	Ht: ____ft. ____in. Wt: _____lbs	Ht: ____ft. ____in. Wt: _____lbs]]

[CALIFORNIA RESIDENTS ONLY, MUST ANSWER # 4]

[4. Are You [, and any Dependents you are applying for,] currently covered for comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan? ❑ Y ❑ N

(Anyone for whom the answer is NO is not eligible for this coverage.)]

***[Caution**: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto; commits a fraudulent insurance act.]*

[**Applicant's Name** John Doe] [[**Social Security #** 111-11-1111] [**ID#** 3423]]

✦✦✦ AGREEMENTS ✦✦✦

To the best of my knowledge and belief all written[, telephonic and electronic] info I gave is true and complete. I understand that my insurance will not go into effect unless [I am actively at work on the effective date.] [I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment.] The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this {request} by the Insurance Company is one of those conditions.

I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
[(3) I may need to take medical tests and report the results to the Insurance Company.]
[(4) My spouse [/Domestic Partner] may need to take medical tests. The results of those tests must be reported to the Insurance Company.]
[(5)] [I must report any change in my health that happens before the insurance is effective.]
[(6)] [I must report any change in the health of my spouse [/Domestic Partner] for whom coverage is requested that happens before the insurance is effective.]
[(7)] Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, [the Medical Information Bureau (MIB)] or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, [or motor vehicle driving record,] of me [or my spouse [/Domestic Partner]] to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for {30} months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law. I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Company is subject to the Gramm-Leach-Bliley act and state privacy laws. It does not disclose protected information except as permitted by those laws.)

☛ **Sign Here** _____ *{Employee's} Signature* _____ *Month/Day/Year* [_____ *Spouse's [/ Domestic Partner's] Signature* _____ *Month/Day/Year*
(If applying for insurance for your Spouse [/Domestic Partner])]

For Home Office use only

[***Notice:*** Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the Insurance Company's privacy practices is available upon request.]

SERFF Tracking #:	*CCGN-128740336*	***State Tracking #:***	***Company Tracking #:*** *12-8002*

State:	*Arkansas*	***Filing Company:***	*Life Insurance Company of North America*
TOI/Sub-TOI:	*H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness*		
Product Name:	*Group Critical Illness Benefits*		
Project Name/Number:	*Evidence of Insurability Form/12-8002*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	10/26/2012
Comments:			
Attachment(s):			
Readability Certification.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application	Approved-Closed	10/26/2012
Comments:			
Attachment(s):			
Appl, EOI form GCI-009320.pdf			

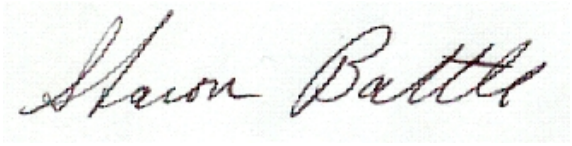
		Item Status:	**Status Date:**
Satisfied - Item:	Description of Variability	Approved-Closed	10/26/2012
Comments:			
Attachment(s):			
Description of Variability.pdf			

Life Insurance Company of North America
1601 Chestnut Street
P.O. Box 7716
Philadelphia, PA 19192-2235

READABILITY CERTIFICATION

We, the Life Insurance Company of North America, certify that we have carefully scored the form listed below, using the Flesch Readability Test, in accordance with applicable readability standards. This score is set forth below.

Form Number	Description of Form	Score
GCI-009320	Application	50.00



Signature: _____

Name: Sharon Battle

Title: Assistant Secretary

Date: 10/8/2012

CRITICAL ILLNESS INSURANCE
[APPLICATION] [EVIDENCE OF INSURABILITY] [ENROLLMENT] [CHANGE] FORM
Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)

[[*For info and customer service for Critical Illness Insurance, call {1-000-000-0000}.*]
[• *All info must be completed by the applicant.*]
• *The applicant, and spouse* [*/Domestic Partner*] *if coverage is requested, must sign and date this form.*
• *This form cannot be considered unless received within {30} days of the date it is dated.*
[• *The Insurance Company must approve your request for insurance before it becomes effective.*]

Important: *Please enter all dates in mm/dd/yyyy format.*]

REASON FOR REQUEST

[❑ NEW HIRE] [❑ INITIAL ENROLLMENT EVENT] [❑ LATE ENTRANT]
[❑ LIFE STATUS CHANGE] [❑ ONGOING ENROLLMENT EVENT] [❑ REINSTATEMENT]

[Please print (preferably in black ink)]

{EMPLOYEE} INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. (Check one) Name: (First) _____ (Last) _____ (MI) ____
Address_____ Apt. # _____ City _____State____ Zip_____
Day Phone _____ Evening Phone _____ Social Security # _____ Date of Birth _____
[Employer _____] [Policy # _____] [ID #_____] [Class _____]
[Occupation _____] [Location _____] [Date of Hire _____] [Annual Salary _____]

[COMPLETE IF ELECTING SPOUSE [/DOMESTIC PARTNER] COVERAGE

[❑ I am currently married and my date of marriage is _____] [❑ I am currently eligible under the insurance as a Domestic Partner*]

Name: (First) _____ (Last) _____ (MI) ____ Social Security # _____ Date of Birth _____

[* *In order to be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or any required Domestic Partner Affidavit on file with your employer, and accepted by the Insurance Company. If you do not currently have a state-registered Domestic Partnership, or an Domestic Partner Affidavit on file with your employer, an Affidavit should be requested from and will be made available to you through your employer.*]]

CRITICAL ILLNESS INSURANCE [Policy Number _____]

[Have you smoked or used any form of tobacco in the last {12} months?
{Employee} ❑ Y ❑ N Spouse [/Domestic Partner] ❑ Y ❑ N]

[Employer-Paid Basic Coverage

Applicant	[Amount]	Guaranteed Issue Amount*
{Employee}	[_____ times salary, to a maximum of $_____]	_____]

Voluntary {Employee}-Paid Coverage

Applicant	Decline	Amount Requested [*(check only one amount)*] [*(amount must be $\{1,000\} increments)*]	[Guaranteed Issue Amount*
{Employee}	❑	[❑ _____] [❑ _____] [❑ _____]	_____
Spouse [/Domestic Partner]	❑	[❑ _____] [❑ _____] [❑ _____]	_____
Child(ren)	❑	[❑ _____] [❑ _____] [❑ _____]	_____]

[Guaranteed Issue Amount is only available during Initial Enrollment and at such other times as identified and outlined in offering materials. Amounts of insurance may be limited by state law.]*

[❑ Health Screening Benefit]
[❑ _____]

[*Premium Amount* $ _____]

[Applicant's Name John Doe] [[Social Security # 111-11-1111] [ID# 3423]]

[I WISH TO MAKE THE FOLLOWING CHANGES TO MY CRITICIAL ILLNESS COVERAGE

Consult with your employer for the coverage election options currently available. When selecting new coverage amounts, please ensure that your election(s) match the amounts[, salary multiples] or unit increments as currently available under your plan.

CHECK THE APPROPRIATE BOXES:

❑ ***Increase, Decrease or Begin Coverage on the Following Individuals as Indicated Below***

[**(Complete the medical questions below if you are electing, or increasing, coverage for yourself or your spouse [/Domestic Partner)**]

Applicant	Current Voluntary Coverage	New Voluntary Coverage	Total Voluntary Coverage
❑ {Employee}			
❑ Spouse [/Domestic Partner]			
❑ Child(ren)			

❑ ***Life Status Change*** ***(check only one of the following boxes, and provide date of change)***

[❑ Marriage] [❑ Divorce] [❑ Annulment] [❑ Legal Separation] [❑ Birth or Adoption of a Child] [❑ Death of Spouse [/Domestic Partner] or Child] [❑ Leave of Absence] [❑ Change in Spouse's [/Domestic Partner's] Employment] [❑ Return to or from Military Duty] [❑ Change from Full-time to Part-time (or vice-versa)]

Date of Life Status Change _____

❑ ***Cancel Coverage on the Following Individuals*** ***(check all that apply)***

❑ {Employee} ❑ Spouse [/Domestic Partner] ❑ Dependent Child(ren)

Effective Date of Cancellation _____

❑ ***Name Change*** ***(Current name / New Name)***

{Employee} _____ / _____

Spouse [/Domestic Partner] _____ / _____]

ACCEPTANCE / DECLINATION

[I accept the insurance coverage(s) chosen above. I authorize my employer to {deduct the needed amounts from my earnings}. If I have not chosen coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability/good health at my own expense and that coverage is subject to the Insurance Company's approval.]

[I authorize the above changes to my {employee} paid coverage. I understand that certain changes may require medical information which will be requested by the Insurance Company if necessary. I authorize my employer to {make the appropriate payroll deductions} for changes noted above.]

Signature_____ Date _____

****You should read and sign the Agreements section that follows in this form****

[Applicant's Name John Doe] [[Social Security # 111-11-1111] [ID# 3423]]

[IMPORTANT
Please complete the following section if needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Instructions for Evidence of Insurability Section

[Complete the employee info in this section if you (i.e., the {Employee}) are:
- applying for Insurance for yourself that is greater than the guaranteed coverage amount, or
- applying for Insurance for yourself [more than {31} days] after you were eligible for the insurance.]

[Complete the spouse [/Domestic Partner] info in this section if:
- applying for Insurance for your spouse [/Domestic Partner] that is greater than the guaranteed coverage amount, or
- applying for Insurance for your spouse [/Domestic Partner] [more than {31} days] after the spouse [/Domestic Partner] is eligible for the Insurance.]

Please indicate your answers for each question by checking the Yes or No box for the question.

	{Employee}	[Spouse [/Domestic Partner]
1. In the past 5 years has any proposed insured received medical advice or treatment for or had:		
• Cancer, carcinoma in situ, blood disorder?	❑ Y ❑ N	❑ Y ❑ N
• Stroke, transient ischemic attack, chronic obstructive lung or pulmonary disease, any disease or disorder of the heart, polycystic kidney disease, chronic renal failure, any liver disorder, diabetes, macular degeneration, retinitis pigmentosa, acquired immunodeficiency syndrome, HIV or organ transplant?	❑ Y ❑ N	❑ Y ❑ N
2. In the past 6 months has any proposed insured:		
• Been recommended to have a diagnostic test related to cancer that has not been taken or for which results have not been received, or had a diagnostic or screening test related to cancer for which follow-up was recommended other than future routine screening?	❑ Y ❑ N	❑ Y ❑ N
• Been treated with three or more medications for high blood pressure?	❑ Y ❑ N	❑ Y ❑ N
3. Indicate Height and Weight	Ht: ____ft. ____in. Wt: _____lbs	Ht: ____ft. ____in. Wt: _____lbs]]

[CALIFORNIA RESIDENTS ONLY, MUST ANSWER # 4]

[4. Are You [, and any Dependents you are applying for,] currently covered for comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan? ❑ Y ❑ N

(Anyone for whom the answer is NO is not eligible for this coverage.)]

***[Caution**: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto; commits a fraudulent insurance act.]*

[**Applicant's Name** John Doe] [[**Social Security #** 111-11-1111] [**ID#** 3423]]

✦✦✦ AGREEMENTS ✦✦✦

To the best of my knowledge and belief all written[, telephonic and electronic] info I gave is true and complete. I understand that my insurance will not go into effect unless [I am actively at work on the effective date.] [I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment.] The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this {request} by the Insurance Company is one of those conditions.

I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
[(3) I may need to take medical tests and report the results to the Insurance Company.]
[(4) My spouse [/Domestic Partner] may need to take medical tests. The results of those tests must be reported to the Insurance Company.]
[(5)] [I must report any change in my health that happens before the insurance is effective.]
[(6)] [I must report any change in the health of my spouse [/Domestic Partner] for whom coverage is requested that happens before the insurance is effective.]
[(7)] Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, [the Medical Information Bureau (MIB)] or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, [or motor vehicle driving record,] of me [or my spouse [/Domestic Partner]] to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for {30} months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law. I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Company is subject to the Gramm-Leach-Bliley act and state privacy laws. It does not disclose protected information except as permitted by those laws.)

☛ **Sign Here** _____ *{Employee's} Signature* _____ *Month/Day/Year* [_____ *Spouse's [/ Domestic Partner's] Signature* _____ *Month/Day/Year*
(If applying for insurance for your Spouse [/Domestic Partner])]

For Home Office use only

[***Notice:*** Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the Insurance Company's privacy practices is available upon request.]

LIFE INSURANCE COMPANY OF NORTH AMERICA (LINA)

DESCRIPTION OF VARIABILITY

GROUP CRITICAL ILLNESS Application/Evidence of Insurability/Enrollment/Change Form
FORM GCI-009320

Information that may be included/excluded based on case specifics is contained in brackets [ ]. Illustrative information including class identifiers, benefit amounts, age ranges, time durations, references to optional benefits and provisions customized to fit the policyholder's benefit plan is bracketed using { }. In no event will the information contained in these bracketed areas be less favorable to an insured person than the minimum standards set forth in your law.

FORM GCI-009320: Application/Evidence of Insurability/Enrollment/Change Form

This form is intended to support:

- initial requests for becoming insured for group critical illness insurance;
- requests for amounts of insurance in excess of the guaranteed amount of insurance;
- requests for changes in insurance that are subject to satisfaction of a medical evidence requirement;
- late enrollment for insurance; and
- reinstatement of insurance.

This form may be used as a combination application and evidence of insurability form, a combined enrollment and change form, or as another combination form of the four types of situations, or as a single situation form. This is for the purposes of obtaining information needed for the administration of the coverage for which the person is eligible (e.g., the person's name address, identification number, coverages accepted, elected, or declined and, if appropriate, the person's agreement to allow the Policyholder to deduct the person's premium contributions). Combining situations in the same document is done in response to the request of the Policyholder. The reasons for such a request involve reducing the need for completing repetitive information that is captured about the individual (e.g., name, address, social security number, age, sex, etc.) when accepting enrollment for, or requesting, insurance coverage; or the need to capture such information in a specific format for the purpose of "feeding" the Policyholder's human resources system or payroll system (again for the purpose of eliminating redundancy). The submitted form includes a demonstration of the type of information that would be captured on the enrollment form.

Despite the flexibility in situations, the medical questions shown in the third page will not vary in content. The questions section will be included or excluded based on the situation for which the form is designed for the Policyholder.

Items bracketed may be included or omitted.

We also want to make the Department aware that in the future, a bar code may be added to capture form number, Policyholder ID, state in which form is used, or routing within our business.

Variability details for form GCI-009320 in particular:

Page 1:

- The entire "For info…" section at top may be included or omitted. When included, the telephone number may change based on business needs of the insurer. When the form is provided in an electronic format, appropriate instructions for completing the on-line form will be provided.
- References to "Domestic Partner" throughout the form, and in the bracketed wording in the "Complete if Electing Spouse…" section, will only be included when the policy is issued in a state that mandates the inclusion of Domestic Partners when dependent coverage is included.
- Reference to "{12}" in the 1st line of the "Critical Illness" section may vary from 12 to 36.

- The blank checkbox shown below the "Health Screening Benefit" line may be used so that an employee may elect a future approved/authorized additional option.

Page 2:

- In "Acceptance/Declination", the 1st paragraph is used when coverage is on a contributory basis, and the 2nd paragraph when the employee requests a change to the coverage that is in force, when such coverage is on a contributory basis. References to deductions may vary, to describe an alternate payment arrangement such as an ACH, credit card, or direct bill transaction.

Page 3:

- The "Important" section may be included or omitted. Directions to the applicant on how to complete the form may be modified to reflect requirements of the electronic format.
- The employee and spouse instruction paragraphs are used depending on the type of coverage elected. Reference to "{31}" may vary from 31 to 90. The "more than {31} days.." wording may be deleted if the requirements for becoming insured, including when first eligible, require proof of insurability. The eligibility requirements are applied at a policy or class level.
- Question #4 to be added only when applicant resides in California.
- The fraud warning may be moved to a separate page, and included with a list of fraud warnings that are mandated in various states, jurisdictions, and U.S. territories. This wording may be modified to comply with state mandates.

Page 4:

- In "Agreements", line 2, this item may be adjusted for use in the third person grammar (e.g. the employee is actively at work on the effective date), or this item may be omitted and replaced by the requirement that the person is not confined in a hospital or institution, or receiving certain medical treatment. The use of variability reflects eligibility requirements applied at a case or class level.
- In "Authorization", "{30}" may be reduced, but in any event the period used will reflect the regulatory requirements of your state.
- In "Notice", text may be modified to accommodate how the form is signed when the form is in electronic format.